ADMINISTERING MEDICATION Policy Code: 6125-E2

Request for Medication to be Given During School Hours

To be completed by physician:

Name of Student_____ School _____

Medication_____ Dosage _____
Medication_____ Dosage _____
Medication_____ Dosage _____
Medication_____ Dosage _____
(No injection will be given except in an extreme emergency, such as allergy to wasp or bee sting.)

Time(s) medication is to be given: a.m. _____ p.m. _____
To be given from (date) _____ to _____
Significant Information (include side effects, toxic reactions, omission reactions):_____
Contraindications for Administration: _____
_____
If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

a. Contact me at my office _____ Telephone _____
b. Take child immediately to the emergency room at _____
c. Other option: _____
This medication will be furnished by parent or guardian within a container properly labeled by a pharmacist with identifying information, (e.g., name of the child, medication dispensed, dosage prescribed, and the time it is to be given).

_____ DEA# _____ Date _____
Physician's Signature

PARENT'S PERMISSION: I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the Macon County Schools Board of Education and their agents and employees from all liability that may result from my child taking the prescribed medication.

_____ _____ _____
Parent or Guardian's Signature Telephone # Date

(School Use Only)

Name and Title of Person to Administer Medication _____

Approved by _____ _____
Principal's Signature Date